

FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department prior to burial, cremation, or removal, and in any event within 72 hours after death.

03859

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03852

1. DECEASED NAME (Type or Print)	First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
	Minnie	Florence	Aholt	<input checked="" type="checkbox"/>	3	28	1969	M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Female	White	Oct. 13, 1886	82 yrs.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. COUNTY OF DEATH					
Maryland	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Frederick	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick	Frederick Mem. Hosp.			Housekeeper			Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Maryland	Frederick	Middletown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Quebec School Rd. RFD2					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Hezekiah				Elizabeth			Baker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT	ADDRESS					
No	-----		Mrs. Grace Miller	Middletown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
486 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fracture Humerus</u> <u>Diuremia</u> ; <u>OBESITY</u> ; <u>ASCVD</u> .									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
3/19 1969				Fell					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
		Home		Middle town		Middle town	Frederick	Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Robert J. Thomas</u>									
EXAMINER'S NAME (Type) R. J. Thomas, M. D. 812 Tollhouse Ave.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)			(County)	(State)
Burial		March 31, 69	Lutheran Cemetery		Middletown			Fred.	Md.
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
Gladhill Co. Middletown, Maryland				APR 1 1969	<u>Charles Judge</u>				

PC880

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03853

03860

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Editha	Middle Ann	Last Arnold	2a. DATE OF DEATH Month March	Day 18	Year 1969	2b. HOUR P.M. 5
3. SEX Female	4. RACE White	5. DATE OF BIRTH November 11, 1879			6. AGE (In years lost birthday) 89	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Frederick	Md.	
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Monocacy Hall	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Frederick	14. FATHER'S NAME First David	Middle Arnold	15. MOTHER'S MAIDEN NAME First Mary	Middle Ann	Last Wiener	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 220-44-6474-J1	17. INFORMANT Mrs. Gertrude Ausherman	Address Burkittsville Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY:          IMMEDIATE CAUSE (o) <u>Coronary thrombosis</u>          4124          DUE TO, OR AS A CONSEQUENCE OF          Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause          (b) <u>Arterosclerotic CVD</u>          DUE TO, OR AS A CONSEQUENCE OF          (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)  <u>Cerebral thrombosis January 1964</u></p>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
<b>22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19, 1968</u>, to <u>18 Mar. 1969</u>, that (I) (we) last saw the deceased alive on <u>18 Mar. 1969</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>							
22b. SIGNATURE <u>James S. Stoner, Jr.</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/19/69			
22d. PHYSICIAN'S NAME (Type) JAMES S. STONER, JR.	22e. ADDRESS WALICERSVILLE, Md 21793						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 21, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery	23d. LOCATION (City or Town) Burkittsville Fred. Md.	(County)	(State)		
24. FUNERAL DIRECTOR Gladhill Company	ADDRESS Middletown, Md.	25a. REG'D. BY REGISTRAR MAR 24 1969	25b. REGISTRAR'S SIGNATURE <u>James Judge</u>				

03850

03861

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03854

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <b>KATE</b>	Middle <b>M.</b>	Lost <b>BIDDLE</b>	2d. DATE OF DEATH Month <b>MARCH</b>	2b. HOUR P. 6:30 M.
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 18, 1878</b>	6. AGE (In years last birthday) <b>90</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Michigan</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Monocacy Hall Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>911 Motter Place</b>	
14. FATHER'S NAME First <b>Charles</b>	Middle <b>H.</b>	Lost <b>Morse</b>	15. MOTHER'S MAIDEN NAME First <b>Julia</b>	Middle <b>Sessions</b>	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <b>Mrs. N. Edward Lightner, 911 Motter Place</b>	Address <b>Frederick, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Cardiac arrest</b> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular disease with dementia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> 5 years 5 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1969</b> , to <b>March 26, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>LeRoy T Davis</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>March 27, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>LeRoy T. Davis, M.D.</b>	22e. ADDRESS <b>228 N. Market St. Frederick, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 28, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) <b>Frederick</b>	(State) <b>Frederick</b>	<b>Md.</b>
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>	25a. ADDRESS <i>Donald M. Etchison</i>		25b. REC'D BY REGISTRAR <b>APR 1 1969</b>	25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	

10280



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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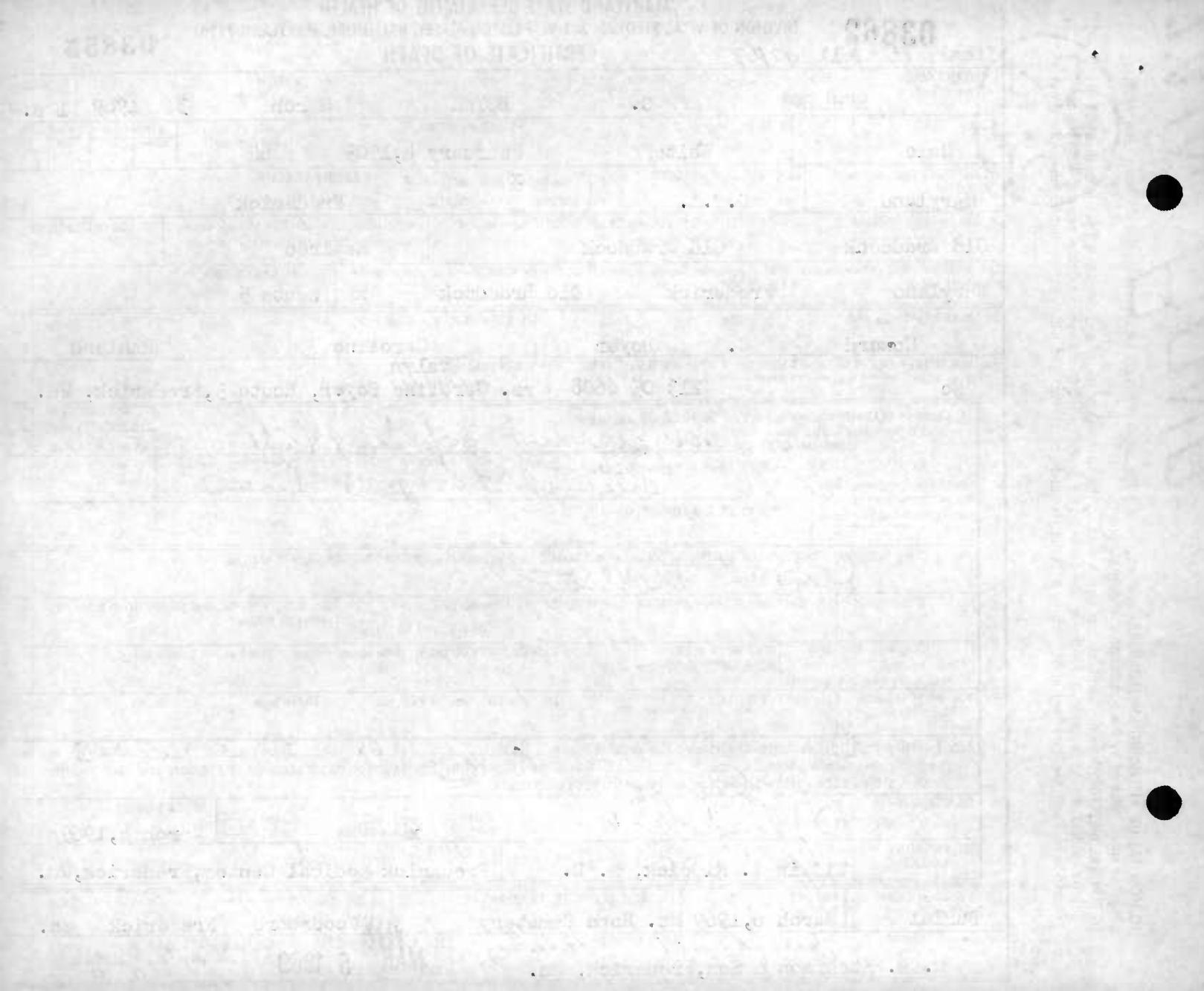
03862  
Item 17 Film 4111 4/2/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03855

1. DECEASED NAME (Type or print)	First <b>RUHLAND</b>	Middle <b>C.</b>	Lost <b>BOYER</b>	2d. DATE OF DEATH Month <b>March</b>	Day <b>3</b>	Year <b>1969</b>	2b. HOUR <b>1 p. m.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>February 4, 1905</b>		6. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>				
10. CITY OR TOWN OF DEATH <b>Old Braddock</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Old Braddock</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>	13b. CITY OR TOWN <b>Frederick</b>	13c. INSIDE CITY LIMITS? <b>YES</b>	13d. NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route 5</b>			
14. FATHER'S NAME <b>Howard</b>	First <b>C.</b>	Middle <b>Boyer</b>	Lost	15. MOTHER'S MAIDEN NAME <b>Caroline</b>	Middle	Lost <b>Ruhland</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>213 05 6608</b>	17. INFORMANT <b>Evelyn</b>	Address <b>Mrs. Caroline Boyer, Route 5, Frederick, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct, Acute</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>							
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Stenocardic heart disease</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (1) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>68</b> , to <b>Mar 3, 19 69</b> , that (1) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Willis J. Riddick</b>							
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <b>Frederick Medical Center, Frederick, Md.</b>	DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>March 4, 1969</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 6, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Hope Cemetery</b>	23d. LOCATION (City or Town) <b>Woodsboro</b>	(County) <b>Frederick</b>	(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>	ADDRESS <b>Donald M. Etchison</b>	25a. REC'D. BY REGISTRAR DATE <b>MAR 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
VR A15 45M - 1							



**1**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**03856**

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)			First <b>Anna</b>	Middle <b>M.</b>	Last <b>Burgess</b>	2a. DATE OF DEATH Month <b>March</b>	Day <b>31</b>	Year <b>1969</b>	2b. HOUR <b>3:00 P.M.</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 15-1882</b>		6. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <b>Frederick</b>			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY _____	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>New Market</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/></b> NO <input type="checkbox"/>		13e. STREET AND NUMBER _____	
14. FATHER'S NAME First <b>George</b>		Middle <b>W.</b>	Last <b>Burgess</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>		Middle <b>A.L.</b>	Last <b>Lehr</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-12-1779</b>		17. INFORMANT <b>Mrs. Charles W. Wiles-Brunswick-Md.</b>		Address <b>21716</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ch. Congestive failure due to A-S heart dis</b> 1962 <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Probable intraabdominal malignancy</b>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input type="checkbox"/></b> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 March, 1969</b> , to <b>31 Mar., 1969</b> , that (I) (we) last saw the deceased alive on <b>31 March, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles H. Conley, Jr. MD</b>		22c. DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Mar. 31-1969</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Prof. Bldg.-Frederick, Md. 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 3-1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Methodist Cemetery</b>		23d. LOCATION (City or Town) <b>New Market-Md. 21774</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>		ADDRESS <b>Whitmore Frederick, Md. 21701</b>		25a. REC'D. BY REGISTRAR <b>APR 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

380

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03864

## CERTIFICATE OF DEATH

03857

1. DECEASED NAME (Type or print) <b>Anna—also Annie</b>				First <b>M.</b>	Middle <b>M.</b>	Last <b>Cavell</b>	2a. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>69</b>	2b. HOUR <b>3:15 M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>			5. DATE OF BIRTH <b>June 20-1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.	IF UNDER 1 YEAR MONTHS    DAYS	IF UNDER 24 HRS. HOURS    MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>				
10. CITY OR TOWN OF DEATH <b>Braddock Hgts.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Vindobona Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY _____			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route 4</b>			
14. FATHER'S NAME First <b>Powell</b>		Middle <b>Ball</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Not available</b>		Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-10-9632D</b>			17. INFORMANT <b>Mrs. Dorothy Shaff-Rt. 4-Frederick, Md. 21701</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4369</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral vascular accident</b>					<b>2 days.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b>		(b) DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic vascular disease</b>					<b>5 years.</b>			
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month <b>March</b> Day <b>13</b> Year <b>1969</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <b>Prof. Bldg.-Frederick, Md. 21701</b>		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1969</b> to <b>March 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>LeRoy T Davis</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED <b>Mar. 14-1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>LeRoy T Davis</b>		22e. ADDRESS <b>Prof. Bldg.-Frederick, Md. 21701</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 17-1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick- Frederick- Md.</b>				
24. FUNERAL DIRECTOR <i>Edward T.</i> <b>M.R. Etchison &amp; Son</b>		ADDRESS <b>7 Whitmore</b> <b>Frederick, Md. 21701</b>			25a. MAR. 17 1969		25b. REGISTRAR'S SIGNATURE <i>Barbara L. Cusack</i>			
					DATE					

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15  
45M - 1/69

20

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

03858

03865

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	20. DATE OF DEATH	2b. HOUR		
				Walter	Rhodes	Clark	Month March	Day 1. Year 1969 2 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	
Male		White		Feb. 13, 1969						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Franklin		Va. USA.				Frederick				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Frederick Md.			709 Magnolia Ave., Mechanical Engineer						Ft Detrick	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Frederick		Frederick				709 Magnolia Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
		Herman		Clark	Elizabeth		Rhodes	Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
NO		244-10-8765		Mrs. Hildred S. Clark		709 Magnolia Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>4109</i> <i>acute (Mature) Coronary atherosclerosis</i> APPROXIMATE INTERVAL <small>BETWEEN ONSET AND DEATH</small> <small>1/2 hr.</small> <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</small> <small>(b)</small> <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>(c)</small>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1966</i> , to <i>3/1/1967</i> , that (I) (we) last saw the deceased alive on <i>3/1/1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert S. Hughes</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED March 1, 1969	
22d. PHYSICIAN'S NAME (Type) Dr. Robert S. Hughes		M.D.	22e. ADDRESS 700 Montclair Avenue Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-4-1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL Hillside Memorial Gardens		23d. LOCATION (City or Town) Plymouth, North Carolina		(County) (State)			
24. FUNERAL DIRECTOR <i>Robert E. Dailey &amp; Son</i>		ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
			DATE MAR 4 1969							

33860

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

**03859**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <b>LUCY</b>	Middle <b>VIRGINIA</b>	Last <b>CLINE</b>	2a. DATE OF DEATH Month <b>March</b>	Day <b>19</b>	Year <b>1969</b>	2b. HOUR <b>5P M</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Oct. 21, 1892</b>		6. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS <b>MIN.</b>
7a. BIRTHPLACE (State or foreign country) <b>Fred. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			
10. CITY OR TOWN OF DEATH <b>Rural-Myersville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route # 1</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route # 1</b>			
14. FATHER'S NAME First <b>Charles</b>		Middle <b>W.</b>	Last <b>Rice</b>	15. MOTHER'S MAIDEN NAME First <b>Mary Ann Derr</b>		Middle <b>Rice</b>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>John H. Cline, Myersville, Md. Rt 1</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 coronary occlusion</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden death</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost.</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive vascular disease</b>		10-20 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 20, 1969</b> , to <b>Mar 19, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. S. Stauffer</b>		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Mar 21, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. S. STAUFFER</b>		22e. ADDRESS <b>Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 22, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion U. M.</b>		23d. LOCATION (City or Town) <b>Myersville, Fred. Co. Md.</b>		(County)	(State)
24. FUNERAL DIRECTOR <b>Paul F. Bittle</b>		ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. George</b>			

8380

RECEIVED  
FEB 12 1968  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WILMINGTON FIELD OFFICE  
WILMINGTON, DELAWARE

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE  
HEALTH DEPT.**

03867

03860

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

ROBERT J. THOMAS, M.D.  
812 TOLL HOUSE AVENUE  
FREDERICK, MARYLAND  
(PDSME 5)  
FORM REV. 1/68

1. DECEASED-NAME (Type or Print)		First MARK	Middle WARD	Lost CROWLEY	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 3	Day 23	Year 1969	2b. HOUR 7 25 M
3. SEX Male	4. RACE Cau	S. DATE OF BIRTH June 1, 1952	6. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3	Day 23	Year 1969	2d. HOUR 7 25 P.M.
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick,						
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Fred. Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) student			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route # K 6				
14. FATHER'S NAME Ward		First William	Middle Crowley	Lost	15. MOTHER'S MAIDEN NAME Anna	Middle Ruth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-56-1395		17. INFORMANT Mr. Ward W. Crowley Rt.# 6 Frederick, Md.	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>CRUSHED SKULL</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>LACERATED BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6 P.M. 3/23 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Auto Accident</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>HIGHWAY</u>		21f. LOCATION Street or R.F.D. No. <u>GAMBRILL PARK RD.</u>		City or Town <u>FREDERICK MD</u>	County <u>MD</u>	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<u>Robert J. Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>3-23-69</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ADDRESS (Street, city, town, or county) <u>Frederick, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-1969		23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery				23d. LOCATION (City or Town) (County) (State) Auto, West Virginia	
24. FUNERAL DIRECTOR <u>Robert E. Dailey</u>		ADDRESS Robert E. Dailey & Son Frederick, Maryland		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE <u>Robert E. Dailey</u>			

63298

on a report of condition

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03868

03861

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours of death.

1. DECEASED-NAME (Type or print)	First Lucy	Middle Ann	Last Cutright	2a. DATE OF DEATH Month 3	Day 30	Year 69	2b. HOUR 11:am		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 19, 1881</b> <b>June 19, 1891</b>			6. AGE (in years last birthday) <b>77</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <b>Frederick</b>						
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Md. Odd Fellows Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired School Teacher</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>105 Stockton, Maryland</b>					
14. FATHER'S NAME First <b>James</b>	Middle <b>M.</b>	Last <b>Hoskins</b>	15. MOTHER'S MAIDEN NAME First <b>Columbia</b>	Middle <b>J.</b>	Last <b>Herndon</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>216-09-5926D</b>	17. INFORMANT <b>Md. Odd Fellows Home, Frederick, Md.</b>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4379</b> <i>Cerebral vascular accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>2 weeks</b> (b) <i>Cerebral arteriosclerotic vascular disease</i> 5 years. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month Day Year <b>March 30 1967</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>65</b> , to <b>March 30 1967</b> , that (I) (we) last saw the deceased alive on <b>March 30 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>DeRoy T Davis</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>228 North Market Street, Frederick, Md.</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. DeRoy T. Davis M.D.</b>		22e. ADDRESS <b>228 North Market Street, Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 2, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parsons Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Md.</b>					
24. FUNERAL DIRECTOR <i>Robert W. Etchison</i>		ADDRESS <b>M. R. Etchison &amp; Son 106 E. Church St. Fred., Md.</b>		25a. REC'D BY REGISTRAR <b>APR 2 1969</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

21850

2

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03862

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Dgy	Year	2b. HOUR			
Carrie				May		Easterday	March	25	1969	4 a. m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.	
Female		White		February 14, 1892			77 yrs.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH						
Maryland		U. S. A.					Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Frederick		Frederick Memorial Hospital Housewife											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER						
Maryland		Frederick		Route 4			Route 4						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Daniel		Michael	Whipp		Mary			Jane	Myers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address						
No		217 32 7273 F2		Donald G. Easterday, Rt. 4, Frederick, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Venia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 4270 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b) <i>Congestive heart failure</i> (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/10, 1969</i> , to <i>3/25, 1969</i> , that (I) (we) last saw the deceased alive on <i>3/24, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Robert S. Hughes</i>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>March 25, 1969</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
Robert S. Hughes, M. D.		700 Montclaire Ave, Frederick, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 27, 1969</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lukes Cemetery</i>			23d. LOCATION (City or Town) <i>Feagaville</i>		(County) <i>Frederick</i>		(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Donald M. Fealeez</i>		ADDRESS <i>M. R. Etchison &amp; Son, Frederick, Md.</i>		25a. REC'D BY REGISTRAR <i>D MAR 27 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Robert S. Hughes</i>						

00360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03870

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03863

1. DECEASED-NAME. (Type or print)	First  MINNIE	Middle  T.	Last  FLEMING	2a. DATE OF DEATH Month March	2b. HOUR Day 22 Year 1969	2b. HOUR IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN
3. SEX  Female	4. RACE  White	S. DATE OF BIRTH  July 24, 1888	6. AGE (In years last birthday) 80			
7a. BIRTHPLACE (State or foreign country)  Maryland	7b. CITIZEN OF WHAT COUNTRY?  U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH  Frederick			
10. CITY OR TOWN OF DEATH  Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Monocacy Hall Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  Housewife	12b. KIND OF BUSINESS OR INDUSTRY  Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  Maryland	13c. CITY OR TOWN  Carroll	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER  Westminster			
14. FATHER'S NAME First  Edward	Middle  F.	Last  Tucker, Sr.	15. MOTHER'S MAIDEN NAME First  Sallie	Middle  Mull	Last  Westminster, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  No	16b. SOCIAL SECURITY NO.  214 10 2977 A	17. INFORMANT  Mrs. C. Edward Cootes, 112 Anchor St.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4124	DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <i>Arteriosclerotic CVD</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  3 days.  (c) <i>10 years.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <i>Chronic pyelonephritis &amp; cerebral thrombosis</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> , to <u>22 May 1969</u> , that (I) (we) last saw the deceased alive on <u>21 March 1969</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE  <i>James E. Stoner, Jr.</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED  March 24, 1969		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS  Walkersville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE  March 25, 1969	23c. NAME OF CEMETERY OR CREMATORIUM  Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.			
24. FUNERAL DIRECTOR  M. R. Etchison & Son, Frederick, Maryland	ADDRESS  <i>Donald M. Etchison</i>	25a. REC'D BY REGISTRAR  DATE MAR 26 1969	25b. REGISTRAR'S SIGNATURE  <i>Charles Judge</i>			
VR A15 45M - 1						

07810



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03864

FOR STATE  
HEALTH DEPT.

13864

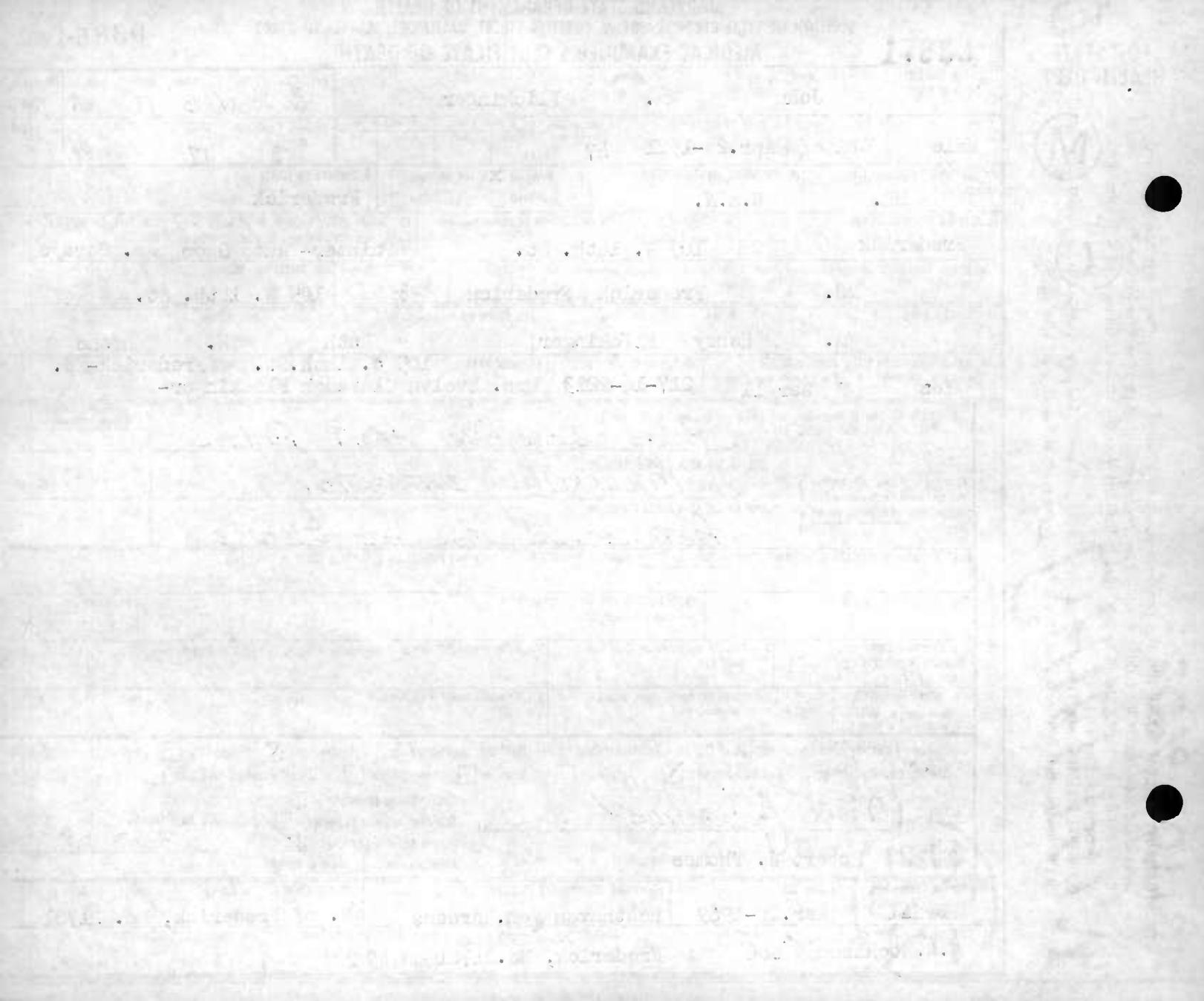
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. DECEASED-NAME (Type or Print)	First John	Middle Wm.	Last Flickinger	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 3	Day 17	Year 1969	2b. HOUR 11:55 A.M.			
3. SEX Male	4. RACE White	S. DATE OF BIRTH Apr. 28-1921	6. AGE (in years lost birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month 3	Day 19	Year 1969	2d. HOUR 9:30 A.M.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick								
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 105 W. 11th. St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter- Auto Shop			12b. KIND OF BUSINESS OR INDUSTRY Re. Garage			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 105 W. 11th. St.							
14. FATHER'S NAME Wm.	First Henry	Middle Flickinger	15. MOTHER'S MAIDEN NAME Ruth N. Boone								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. W War II	17. INFORMANT 217-16-2213	18. ADDRESS Frederick-Md. Mrs. Evelyn Clabaugh Flickinger-								
19. b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c) Acute Congestive Heart Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF Anterioangiocardiac Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State								
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Robert J. Thomas						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 3-17-69					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 20-1969	23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens	23d. LOCATION (City or Town) N. of Frederick, Md. 21701	(County)	(State)						
24. FUNERAL DIRECTOR M.R. Etchison & Son	ADDRESS Whitmore Frederick, Md. 21701	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Stanley J. Gage								



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03865

03872

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Olive	Middle Wesley	Last Ford	2a. DATE OF DEATH Month 3	Day 5	Year 69	2b. HOUR 7:45a.m.
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>November 25, 1892</b>			6. AGE (In years lost birthday) <b>76</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>				
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Md. I.O.O.F.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>3408 Chestnut Avenue</b>				
14. FATHER'S NAME First <b>Robert</b>	Middle <b>J.</b>	Last <b>Ford</b>	15. MOTHER'S MAIDEN NAME <b>Johanna</b>	Middle <b>C.</b>	Last <b>Ford</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>217-01-9816 A</b>	17. INFORMANT <b>Md. Odd Fellows Home, Frederick, Md.</b>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4339</b> <i>Cerebral thrombosis</i>						<b>4 weeks</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic vascular disease</i>						<b>3 years.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1968, to <b>March 5, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Le Roy T. Davis</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>March 5, 1969</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>228 North Market Street, Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 7, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore Cemetery</b>	23d. LOCATION (City or Town) <b>Baltimore, Balt. Md.</b>		(County)	(State)
24. FUNERAL DIRECTOR <i>Robert W. Kee</i>		ADDRESS <b>M. R. Etchison &amp; Son 106 E. Church St. Fred. Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1969</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

2782

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2000-01-01 00:00:00 2000-01-01 00:00:00

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with farm P.M. Page 5 may be retained for your files.

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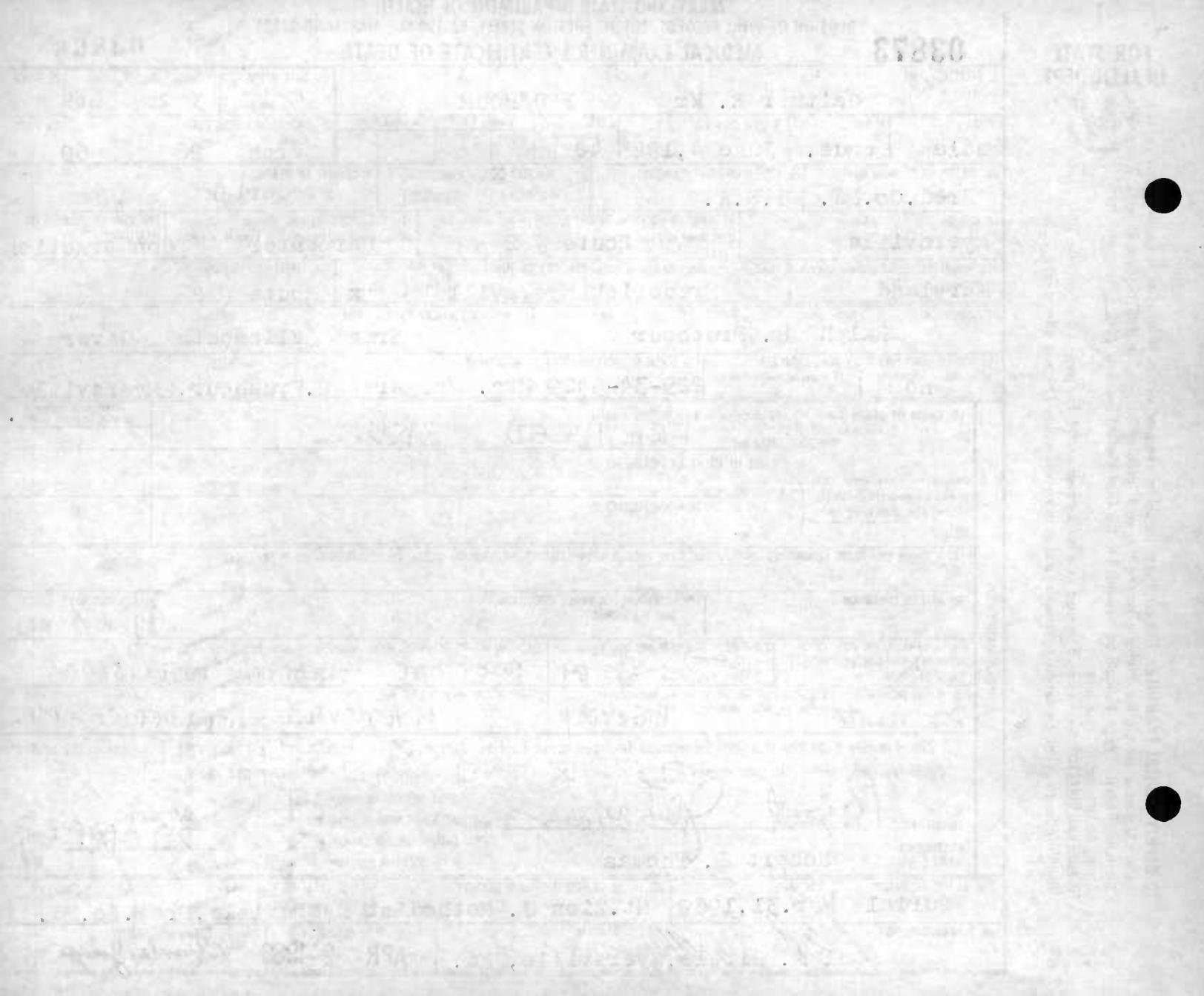
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03873

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03866

1. DECEASED NAME (Type or Print)	First  Gaither R. Kr	Middle  FRUSHOUR	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month 3	Day 28	Year 1969	2b. HOUR M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			2d. HOUR	
male	caus.	June 4, 1928	40 YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. COUNTY OF DEATH	Frederick				
Fred. Co. Md.	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Route # 2				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Carpenter		
Myersville						12b. KIND OF BUSINESS OR INDUSTRY	construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Maryland	Frederick	Myersville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Route # 2					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
	Ralph	B.	Frushour	Erma	Elizabeth	Gaver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
no	229-34-5429	Mrs. Margaret L. Frushour, Myersville							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?							
		<input checked="" type="checkbox"/>							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5 3-28 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		TWO CAR - HEADON - COLLISION							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
	HIGHWAY								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	22b. DATE SIGNED 29 MAR 69								
ACTUAL SIGNATURE Robert J. Thomas	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)								
EXAMINER'S NAME (Type) Robert J. Thomas	Charles Judge								
23a. BURIAL, CREMATION, REMOVAL FOR SCIENTIFIC STUDY	23b. DATE Mar. 31, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion U. Methodist	23d. LOCATION (City or Town) Myersville, Fred. Co. Md.	(County)	(State)				
24. FUNERAL DIRECTOR Paul F. Bittie	ADDRESS Myersville, Md.	25a. REC'D BY REGISTRAR APR 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge						
VR A15ME (5) 10M REV. 1/68									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03867

CERTIFICATE OF DEATH

03874

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR 138	
				Joseph	Francis	Geiselman	March	17	1969		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		March 19, 1912			56 yrs.				
7o. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		U.S.A.					Frederick				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Emmitsburg		R.D. # 1			Mechanic			Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Frederick		Emmitsburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. # 1			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
		Charles E.	Geiselman	Sr.				Marie McNulety			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			21727	
Yes		WW 2		Charles E. Geiselman, Emmitsburg, Md. R.D. # 1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Uncontrolled Diabetes Mellitus</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), DUE TO, OR AS A CONSEQUENCE OF lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19o. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21o. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>March 17, 1969</i> , to <i>March 17, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 17, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. R. Cadle</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>March 17, 1969</i>					
22d. PHYSICIAN'S NAME (Type)		Dr. W. R. Cadle			22e. ADDRESS Emmitsburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 20, 1969		23c. NAME OF CEMETERY OR CREMATORIAL St. Anthony's Shrine			23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md.		(County) (State)		
Burial											
24. FUNERAL DIRECTOR		ADDRESS Emmitsburg, Md.			25a. REG'D BY REGISTRAR MAP 19 1969		25b. REGISTRAR'S SIGNATURE <i>C. E. Wilson</i>				
					DATE						
Clarence E. Wilson											

51258

**ROBERT DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. File page 3 with the funeral home.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03868

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
LEVI			T.	GRAY		<input checked="" type="checkbox"/>	3	26	1969	M	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS      DAYS	IF UNDER 24 HRS. HOURS      MIN.	2c. DATE PRONOUNCED DEAD					
Male	White	Aug. 24, 1906	62 yrs.			Month	Day	Year	2d. HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural-Mt. Airy			Route 4			Warehouseman					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Frederick Mt. Airy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 4		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Tildon			H.		Gray	Sarah					Aleshire
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes, enter your number of service)			17. INFORMANT			62 ADDRESS 44th Ave. Clarence W. Gray Riverdale, Md.		
Yes			WW 2			214-12-4737					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arterio sclerotic</u> (c) <u>Cardiovascular Disease</u> last.											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Robert J. Thomas</u> M.D.											
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALY			23d. LOCATION (City or Town)		(County)	(State)	
Burial		3/29/1969		Locust Grove			Frederick, Md.				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
C. M. Waltz, Box 241, Sykesville, Md.					APR 2 1969		<u>Charles Judge</u>				

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03869

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2o. DATE OF DEATH Month Day Year	2b. HOUR 7:45 PM
2. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
3. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
WALKERSVILLE, MARYLAND	GOLDSBORO PLACE			SHIPPING WORK	CEMENT
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
JOHN GRIMES				AURA FISHER	MD. WALKERSVILLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war number or date of service)	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	No 171-05-7793	MRS. F. E. SOFINOWSKI, WALKERSVILLE	Jan. 1968		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Metastatic carcinoma					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Metastatic lower right mandible					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town
				County	State
22a. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1968, to March 14, 1969, that (I) (we) last saw the deceased alive on Jan 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E.A. Dettbarn, M.D.		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS WALKERSVILLE, MD. 21713			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/17/69	23c. NAME OF CEMETERY OR CREMATORIUM MT. VIEW CEM.	23d. LOCATION (City or Town) UNION BRIDGE	(County) (State) MD.
24. FUNERAL DIRECTOR		ADDRESS D.D. HARTZLER & SONS UNION BRIDGE	25a. RECD BY REGISTRAR MAR 19 1969	25b. REGISTRAR'S SIGNATURE	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03870

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First NELLIE	Middle VICTORIA	Last Grove	2a. DATE OF DEATH Month March	2b. HOUR Year 1969 1:40 P.M.
3. SEX Female	4. RACE Caucasian	S. DATE OF BIRTH Nov. 19, 1876	6. AGE (In years last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Frederick,		
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 143 West Patrick Street	
14. FATHER'S NAME First Luther	Middle C.	Last Derr	15. MOTHER'S MAIDEN NAME Victoria	Middle Fraley	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 219-54-6905	17. INFORMANT Mr. Benjamin F. Grove, Jr.	Address 143 W. Pat. St.	Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive failure heart</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James B. Thomas, M.D.</u>		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED March 3, 1969	
22d. PHYSICIAN'S NAME (Type) Dr. James B. Thomas,		M.D.	22e. ADDRESS 228 N. Market Street	Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-6-1969	23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery	23d. LOCATION (City or Town) Frederick,	(County) Frederick, Md. (State)
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u>		ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR MAR 6 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

77880

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03871

CERTIFICATE OF DEATH

03878

1. DECEASED-NAME (Type or print)	First Donald	Middle Wayne	Last Grumbine	2a. DATE OF DEATH March Month 15 Doy 69 Year	2b. HOURS 10:45 M
3. SEX Male	4. RACE White	S. DATE OF BIRTH Sept. 13-1941	6. AGE (in years last birthday) 27 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick	Md.	
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Handicapped-Blind	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route 4	
14. FATHER'S NAME First Wm.	Middle E.	Last Grumbine	15. MOTHER'S MAIDEN NAME Ruth	Middle V.	Last Dudrow
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-40-3910	17. INFORMANT Mrs. Shirley G. Gross-1601-18th St. N.W.-	Address Wash.-D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
(b) DUE TO, OR AS A CONSEQUENCE OF Hannel-Striel-Wilson DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus			2 years 23 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James B. Thomas	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Mar. 15-1969	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Prof. Bldg.-Frederick-Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 18-1969	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery	23d. LOCATION (City or Town) Woodsboro- Md. 21798	(County)	(State)
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son	ADDRESS Frederick, Md. 21701	25a. REC'D BY REGISTRAR MAR 18 1969	25b. REGISTRAR'S SIGNATURE Charles Under		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11337

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 2 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First <b>baby</b>	Middle <b>girl</b>	Last <b>Hardy</b>	2a. DATE OF DEATH Month <b>3</b>		2b. HOUR Day <b>21</b> Year <b>69</b> 3:30p M		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>3/21/69</b>		6. AGE (In years last birthday) YRS. —		IF UNDER 1 YEAR MONTHS —	IF UNDER 24 HRS DAYS —	MIN <b>30</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>				
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) —		12b. KIND OF BUSINESS OR INDUSTRY —				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Park Place</b>				
14. FATHER'S NAME First <b>Thomas</b>		Middle <b>Clifton</b>	Last <b>Hardy</b>	15. MOTHER'S MAIDEN NAME First <b>Gay Diane Hawkins</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>none</b>		17. INFORMANT mother		Address <b>123 Stewart Manor Apts, Fred, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anencephaly, meningomyelocele</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>740X</b> (b) <b>fetal anomaly incompatible with life</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>premature birth (2#12oz.)</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. — 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>69</b> , to <b>3/21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive an <b>30 min.</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Harry W. Gray</i>		MD DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/21/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Harry W. Gray, M. D.</b>		22e. ADDRESS <b>Frederick, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3/23/69</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mark's Cemetery, Petersville, Fred, Co., Md.</b>		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <b>Feete Funeral Home</b>		ADDRESS <b>Brunswick, Md.</b>		24a. DATE OF REGISTRATION <b>3/23/69</b>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>				

1980 COMMERCIAL AIRPORTS  
UNITED STATES, 1982 TO 1983: VOLUME AND USE OF AIRPORTS

UNIT 10. Headlines

Year

City

State

Region

Number of airports in the United States increased from 1982 to 1983.

Small rural airports in the United States increased from 1982 to 1983.

Commercial airports were visited more frequently in 1983 than in 1982.

Large airports in the United States increased from 1982 to 1983.

The number of passengers per flight increased in 1983.

Commercial flights increased.

Passenger traffic increased in 1983.

FOR STATE  
HEALTH DEPT.

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in Item 18. Give Pages 1, 2, and 3 to

the Chief Medical Examiner's Office along with farm PM3. Page

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03873

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First <b>Elias</b>	Middle <b>Milo</b>	Last <b>Hooper-Sr.</b>	2a. DATE OF DEATH Month <b>Mar.</b> Day <b>19</b> Year <b>69</b>	2b. HOUR <b>10:10</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 7-1898</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer-Live Stock Dealer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 10</b>	
14. FATHER'S NAME First <b>James</b>		Middle <b>O.</b>	Last <b>Hooper</b>	15. MOTHER'S MAIDEN NAME First <b>Lillie</b>		Middle <b>May</b>	Last <b>Stottlemeyer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>None</b>		17. INFORMANT <b>Mrs. Ruth M. Hooper-Route 10-Frederick-Md.</b>		Address <b>21701</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109</b>		Shock						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>-----</b>		(b) Myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF <b>-----</b>		(c) <b>-----</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>-----</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b>-----</b>		City or Town <b>-----</b>	County <b>-----</b>	State <b>-----</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/19/69</b> , 19 <b>-----</b> , to <b>3/19/69</b> , 19 <b>-----</b> , that (I) (we) last saw the deceased alive on <b>3/19/69</b> , 19 <b>-----</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. Austin Pearre Jr.</i>		DEGREE <b>-----</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Mar. 20-1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. A.A. Pearre-Jr.</b>		22e. ADDRESS <b>804 Toll House Ave., Frederick, Md. 21701</b>							
23a. BURIAL, CREMATION, REMAVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 22-1969</b>		23c. NAME OF CEMETERY OR CREMATRY <b>Pleasant Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nr. Yellow Springs, Md.</b>			
24. FUNERAL DIRECTOR <b>Elwood T. M. R. Etchison &amp; Son</b>		ADDRESS <b>Whitmore Frederick, Md.</b>		25a. REC'D. BY REGISTRAR <b>Mid 24 1969</b>		25b. REGISTRAR'S SIGNATURE <i>John George</i>			
VR A13 45M - <i>John George</i>									

EX-860

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
APRIL 10 1968

02858

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03881

03874

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>John</i>	Middle <i>Russell</i>	Last <i>Huff</i>	2a. DATE OF DEATH Month <i>3</i>	Day <i>10</i>	Year <i>69</i>	2b. HOUR <i>75 AM</i>				
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Dec. 9, 1893</i>			6. AGE (in years last birthday) <i>75</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>				
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Frederick</i>						
10. CITY OR TOWN OF DEATH <i>Mountaintdale</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>-</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>		13c. CITY OR TOWN <i>Mountaintdale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>-</i>					
14. FATHER'S NAME First <i>William</i>		Middle <i>Huff</i>	Last <i>Huff</i>	15. MOTHER'S MAIDEN NAME First <i>Annie</i>		Middle <i>Mackley</i>	Address <i>Mrs. Eleanor Y. Huff, Thurmont, Md.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)									16b. SOCIAL SECURITY NO. <i>578-03-5216A</i>	17. INFORMANT <i>Cecilian &amp; Lesie</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>185x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Concussion &amp; Lesions</i>									DUE TO, OR AS A CONSEQUENCE OF (b) <i>Convalescence of prostate</i>	DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION <i>1905</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Prostate's enlargement</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>3/5/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <i>3/10/69</i>			
22b. SIGNATURE <i>Robert H. Pilgram MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Po Box 5, Bldg. Frederick, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/13/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel Cemetery</i>			23d. LOCATION (City or Town) <i>700 Libertytown Rd. Frederick, Md.</i>		(County)	(State)			
24. FUNERAL DIRECTOR <i>G.C. Barton, Walkersville, Md. 21793</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>D MAR 13 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Robert H. Pilgram</i>						

18380

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03875

1. DECEASED NAME (Type or Print)		First <b>ADAM</b>	Middle <b>James</b>	Lost	20. DATE KNOWN TO OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month <b>3 - 15</b>	Day <b>1969</b>	Year <b>8 PM</b>	2b. HOUR <b>20</b>		
3. SEX <b>male</b>	4. RACE <b>negro</b>	S. DATE OF BIRTH <b>7/15/1910</b>	6. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR MONTHS <b>58</b>	IF UNDER 24 HRS DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>March</b>	Doy <b>19</b>	Year <b>19</b>	2d. HOUR <b>M</b>
7b. COUNTRY <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>					
10. CITY OR TOWN OF DEATH <b>Petersville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Petersville</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>No 10</b>							
14. FATHER'S NAME <b>Charles</b>	Middle <b>James</b>	Lost	15. MOTHER'S MAIDEN NAME <b>Fannie</b>	Middle <b>Price</b>	Lost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>230-18-3084</b>	17. INFORMANT <b>Mrs. Julia James-Knoxville, Md. R.F.D.I</b>	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>8/14/7</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>FRACTURED SKULL &amp; LAC. BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
19c. MEDICAL CERTIFICATION					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>7/15 1969</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <b>HIT BY MOTOR VEHICLE</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>	21f. LOCATION Street or R.F.D. No. <b>RTE 180 - PETERSVILLE - FREDERICK - MD.</b>	City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED <b>16 MAR 69</b>	
ACTUAL SIGNATURE <b>Robert J. Thomas</b>		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>Robert J. Thomas M.D.</b>		22d. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>St. Mary's Cemetery</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/19/69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) <b>petersville</b>	(County) <b>Fred. Md.</b>	(State) <b>MD</b>						
24. FUNERAL DIRECTOR <b>Feete Funeral Home</b>	ADDRESS <b>Brunswick, Md.</b>	25a. RECD BY REGISTRAR DATE <b>MAR 18 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								
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Items 18&22a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH  
4-8-69 a.m.s DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03876

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday) — YRS. 5	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		2d. HOUR	
Female	Negro	10-21-1968	7b. CITIZEN OF WHAT COUNTRY? Maryland	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 131 W. South Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 131 W. South Street						
14. FATHER'S NAME Charles Lee Jenkins		15. MOTHER'S MAIDEN NAME D'Jaris Eileen Henderson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Charles L. Jenkins 131 W. South Street			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (c) (b) <u>Acute bronchitis, pneumococcal &amp; S. Aureus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Endocardial fibroelastosis</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Robert J. Thomas</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Frederick, Md</i>			22b. DATE SIGNED <i>27 MAR 69</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-29-1969		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Catholic			23d. LOCATION (City or Town) (County) (State) Libertytown Fred. Md			
24. FUNERAL DIRECTOR C.E. Hicks, 111 263 W. Patrick St, Fred. Md		ADDRESS			25a. REC'D BY REGISTRAR DATE APR 1 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03877

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Oscar</i>	Middle 	Lost <i>Joy</i>	20. DATE OF DEATH Month <i>March</i>	Day <i>25</i>	Year <i>1969</i>	2b. HOUR <i>9:00 AM</i>									
3. SEX <i>Male</i>		4. RACE <i>W</i>	5. DATE OF BIRTH <i>JULY 12 - 1894</i>		6. AGE (In years last birthday) <i>74</i>		IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. DAYS <i>0</i>		HOURS <i>0</i>		MIN. <i>0</i>				
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>FREDERICK</i>											
10. CITY OR TOWN OF DEATH <i>FREDERICK</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CARPENTER &amp; PAINTER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>REPAIR</i>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>FREDERICK</i>		13c. CITY OR TOWN <i>LIBERTYTOWN</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>NONE</i>									
14. FATHER'S NAME First <i>CHARLES E</i>		Middle 	Last <i>JOY</i>	15. MOTHER'S MAIDEN NAME First <i>MARY</i>		Middle 	Last <i>CATHERINE</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>212-24-6495</i>		17. INFORMANT <i>GENEVIEVE JOY</i>		Address <i>LIBERTYTOWN MD</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4319</i>		Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arterio - sclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Cerebral Arterio - sclerosis</i>		10 years													
(b)		DUE TO, OR AS A CONSEQUENCE OF <i>Arterio - sclerosis</i>															
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterio - sclerosis C.V. Diseases</i> 10 years																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1, 1955</i> , to <i>March 25, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 24, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Bernard O. Thomas Jr.</i>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED <i>March 25, 1969</i>													
22d. PHYSICIAN'S NAME (Type) <i>Bernard O. Thomas Jr.</i>		22e. ADDRESS <i>Fredrick, Md 21701</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3/28/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>FAIRMOUNT</i>		23d. LOCATION (City or Town) <i>LIBERTYTOWN</i>		(County) <i>MD</i>		(State) <i>MD</i>							
24. FUNERAL DIRECTOR <i>John Hartman &amp; Sons Libertytown</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAR 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

2220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03885

03878

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH 3 Month 26 Day 1969 Year	2b. HOUR 5 A.M.	
MARGARET ELIZABETH KEENEY							
3. SEX <b>F</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4/10/1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.	
7b. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>FREDERICK</b>	
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FREDERICK NURSING CONV. CENTER</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>M.D.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>MIDDLEBURY</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>NONE</b>	
14. FATHER'S NAME First <b>SAMUEL</b>		Middle <b>SMITH</b>	Lost	15. MOTHER'S MAIDEN NAME First <b>CLARA</b>		Middle <b>ZECH</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MARGARET MAIN UNION BRIDGE MD</b>		Address	
						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>adhesions of sigmoid 1/2 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) <b>recto - vaginal fistula</b>							
19c. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>68</b> , to <b>3/26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> , 19 <b>67</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Frank Dunnigan MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>3/26/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Frank Dunnigan MD</b>		22e. ADDRESS <b>700 Maryland Ave Fred. Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAR 29-1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>BEAVER DAM</b>		23d. LOCATION (City or Town) <b>UNION BRIDGE RURAL</b>	(County) <b>MD</b>
24. FUNERAL DIRECTOR <b>OB Hartley Sons Union Bridge</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>parents judge</b>	

8-920

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08/20/10 BY 64108270

22380

03886

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03879

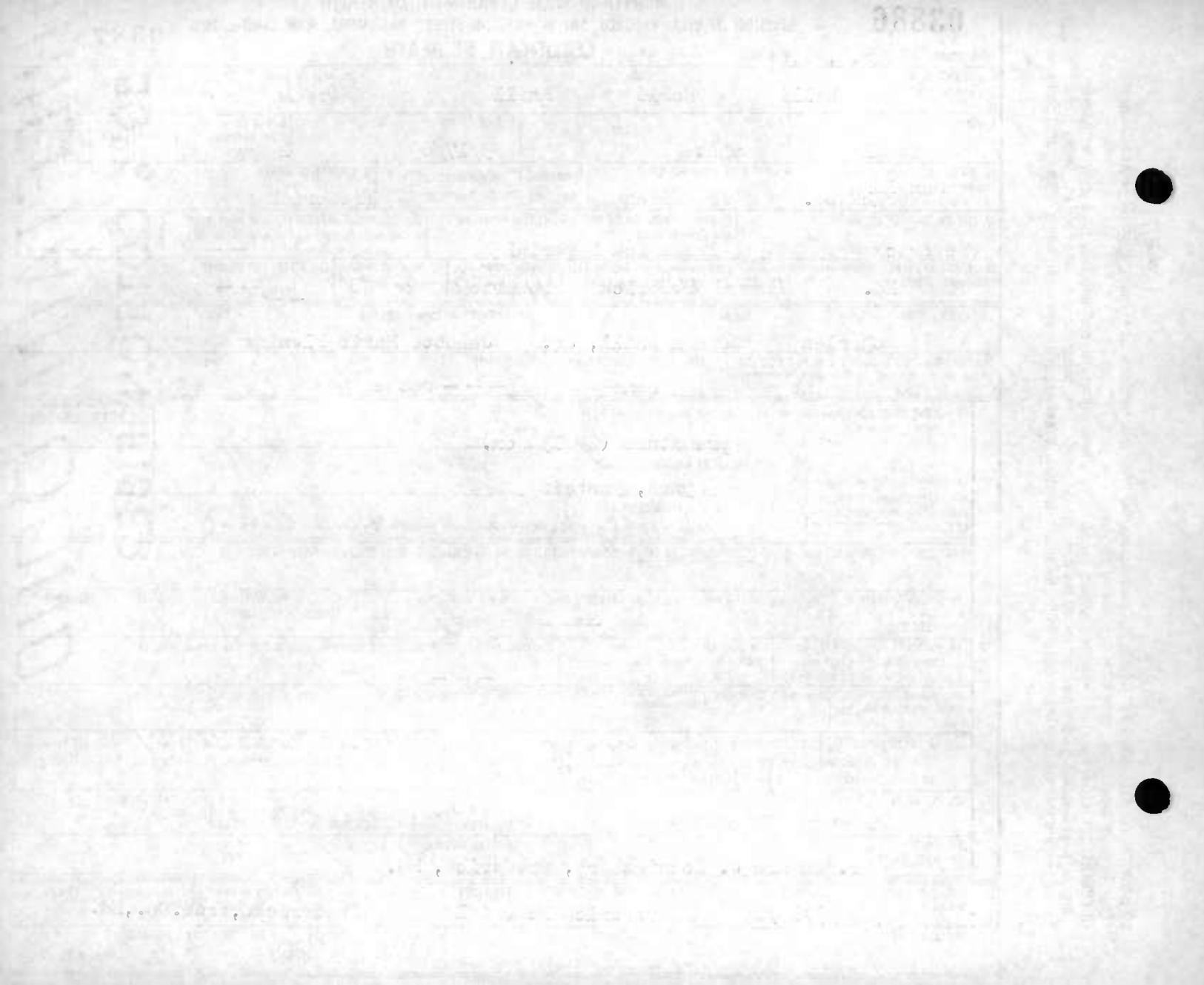
Items #13b, c, d, &amp; e, taken from birth certificate.

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Kelli	Middle Marie	Lost Knill	2a. DATE OF DEATH March 18 1969	2b. HOUR 9:45PM
3. SEX female	4. RACE white	S. DATE OF BIRTH 3/17/69	6. AGE (in years last birthday) 1 day - yrs.	IF UNDER 1 YEAR MONTHS    DAYS    HOURS    MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland Frederick Co.	7b. CITIZEN OF WHAT COUNTRY? Frederick	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick		
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) -----	12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Howard Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route # 2		
14. FATHER'S NAME Charles	Middle Gordon Knill, Jr.	15. MOTHER'S MAIDEN NAME Janette Marie Fleming	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. no	17. INFORMANT ----- mother	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776 / IMMEDIATE CAUSE (a) premature (2# 13½ oz) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) apnea, cyanosis DUE TO, OR AS A CONSEQUENCE OF (c) Probably hyaline membrane disease					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -----		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from March 17 1969, to March 18 1969, that (I) (we) last saw the deceased alive on March 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward Koenigsberg		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3/18/69
22d. PHYSICIAN'S NAME (Type) Dr. Edward J. Koenigsberg, Frederick, Md.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Release hospital	23b. DATE 3/18/69	23c. NAME OF CEMETERY OR CREMATORIAL Frederick Memorial	23d. LOCATION (City or Town) Frederickd, Fred. Co., Md.	(County)	(State)
24. FUNERAL DIRECTOR Charles Atwell, Cremation Memorial Chapel	ADDRESS	25a. REC'D BY REGISTRAR MAR 24 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03887

03880

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, **page 2**, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Thurston	Middle Theodore	Lost Lincks.	2a. DATE OF DEATH Month 15 Day 69 Year May 15 69	2b. HOUR 11:00 AM
3. SEX <i>m</i>		4. RACE <i>w</i>		S. DATE OF BIRTH 4/16/1911	6. AGE (In years 57 57 birthday) YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick	
10. CITY OR TOWN OF DEATH. Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Trackman-B&O R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN FrederickKnoxville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Lewis Henry		Middle Lincks	Lost	15. MOTHER'S MAIDEN NAME First Lovetta		Middle Viola Last Cooper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, or unknown		16b. SOCIAL SECURITY NO. 220-09-8290		17. INFORMANT Mrs. Hilda Stella Lincks-Knoxville, Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of the colon &amp; carcinoma of liver</i> 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last.						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic cardiovascular disease &amp; myocarditis ischemia</i>						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>14 Feb 69</i> , to <i>15 Mar 69</i> , that (I) (we) last saw the deceased alive on <i>15 Mar 69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>George I. Smith</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>15 Mar 69</i>	
22d. PHYSICIAN'S NAME (Type) George I. Smith, Jr. M.D.		22e. ADDRESS 804 Toll House Ave. Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/69		23c. NAME OF CEMETERY OR CREMATORIUM Park Heights Cemetery		23d. LOCATION (City or Town) Brunswick, Md. (County) (State)
24. FUNERAL DIRECTOR Feete Funeral Home-Brunswick, Md.		ADDRESS		25a. REC'D. BY REGISTRAR MAR 18 1969		25b. REGISTRAR'S SIGNATURE <i>Judge</i>
VR A13 45M -		DATE				



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03881

03888

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR	
Ralph	Thurston	*****	Lyles	<input checked="" type="checkbox"/>	March	25	1969	4 p.m.	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2d. HOUR	
Male	Negro	10-22-1920	48 yrs.					2d. HOUR	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. COUNTY OF DEATH						
Maryland	U.S.A.	Sep <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Frederick						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Ijamsville	Bethesda Rd Btl				Plumbers Helper				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md	Frederick	Ijamsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Bethesda Rd. Bt 1					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Clarence Henry Lyles				Ella May	Virginia	Lyles		ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.				17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No	*****				Russell Lyles				Hyattstown Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE									
492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COR PULMONALE (c) PULMONARY EMPHYSEMA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.				City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED
ACTUAL SIGNATURE Robert J. Thomas M.D.									26 MAR 69
EXAMINER'S NAME (Type) Robert J. Thomas									CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Frederick, Md
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-29-1969	23c. NAME OF CEMETERY OR CREMATORIUM Fairview				23d. LOCATION (City or Town) Frederick	(County) Fred. Md	(State)
24. FUNERAL DIRECTOR		ADDRESS C.E. Hicks, 111 Frederick, Md				25a. REC'D. BY REGISTRAR APR 1 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03889

03882

2b. TIME  
12:30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First <b>JOSEPH</b>	Middle <b>ALLEN</b>	Last <b>McABEE</b>	2a. DATE OF DEATH Month <b>March</b>	Day <b>7</b>	Year <b>1969</b>	2b. TIME <b>12:30</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 6, 1905</b>			6. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>Frederick</b>						
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>Limekiln, Maryland</b>					
14. FATHER'S NAME First <b>Joseph</b>		Middle <b>Franklin</b>	Last <b>Mcabee</b>	15. MOTHER'S MAIDEN NAME First <b>Eliza</b>			Middle <b>Funk</b>		Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>217 05 4476</b>			17. INFORMANT <b>Mrs. A. K. Leon, 326 Lindbergh Ave.</b>		Address <b>Frederick, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>										<b>12 hours</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>49a x</b>										DUE TO, OR AS A CONSEQUENCE OF <b>Cor Pulmonale</b>		
DUE TO, OR AS A CONSEQUENCE OF <b>(b) Cor Pulmonale</b>										<b>6 mos(?)</b>		
DUE TO, OR AS A CONSEQUENCE OF <b>(c) Chronic Pulmonary Emphysema</b>										<b>10 yrs (+)</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1968</b> , to <b>7 March 1969</b> , that (I) (we) last saw the deceased alive on <b>7 March 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Charles H. Conley, Jr. M.D.</b>		DEGREE <b>J.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>7 March 1969</b>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>228 N. Market Street, Frederick, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 10, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Frederick Memorial Hospital</b>			23d. LOCATION (City or Town) <b>Frederick</b>		(County) <b>Frederick</b>		(State)	
24. FUNERAL DIRECTOR <b>Donald M. Etchison</b>		ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. RECD BY REGISTRAR <b>MAK 11 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>						

£88.0

~~FOR STATE  
HEALTH DEPT.~~

~~TO DEPUTY MEDICAL EXAMINER:~~ This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

~~TO FUNERAL DIRECTOR:~~ Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a Film GL10 MARYLAND STATE DEPARTMENT OF HEALTH Items 18-22 film 410  
3/20/69 kcc DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3-21-69 ams

03890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03883

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2o. DATE KNOWN OF ESTI- DEATH MATED	Month	Doy	Year	2b. HOUR
Robert Hunter McAfee						<input checked="" type="checkbox"/>	3	10	1969	M
3. SEX <b>male</b>	4. RACE <b>white</b>	S. DATE OF BIRTH <b>5-12-1910</b>	6. AGE (In years lost/birthday) <b>58 yrs</b>	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN	2c. DATE PRONOUNCED DEAD Month <b>Mar.</b> Doy <b>10</b> Year <b>1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			2d. HOUR	
10. CITY OR TOWN OF DEATH <b>Thurmont</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Lantz</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>rural</b>		
14. FATHER'S NAME <b>Ruban McAfee</b>		First	Middle	Lost	15. MOTHER'S MAIDEN NAME <b>Rosa P. Lewis</b>		First	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>212-14-6570</b>		17. INFORMANT <b>Nora McAfee</b>		ADDRESS <b>Lantz, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> due to, or as a consequence of <b>Environmental exposure - Freezing</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ due to, or as a consequence of <b>Acute alcoholism</b> (c) _____</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p>										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Doy, Year HOUR A.M. <b>P.M.</b> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Robert J. Thomas</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Robert J. Thomas</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)</p>										22b. DATE SIGNED <b>10 MAR 69</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-12-69</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Methodist Cem.</b>		23d. LOCATION (City or Town) <b>Garfield Fred. Co. Md.</b>		(County)	(State)	
24. FUNERAL DIRECTOR <i>Raymond E. Creager</i>		ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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03891

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film 411 4/2/69 kk

## CERTIFICATE OF DEATH

03884

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM 3 22 69 11:10		
<b>Sarah</b>		<b>Tiller</b>	<b>Miller</b>		Month 3 Day 22 Year 69	IF UNDER 1 YEAR MONTHS 5 DAYS 6 HOURS MIN.		
3. SEX <b>female</b>		4. RACE <b>caucasion</b>		5. DATE OF BIRTH <b>10/16/72 1882</b>		6. AGE (In years last birthday) <b>86</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <b>Beverly</b>		Middle <b>Welford</b>	Last <b>Brown</b>	15. MOTHER'S MAIDEN NAME First <b>Margaret</b>		Middle <b>Virginia</b>	Last <b>Walter</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>219 54 0693</b>		17. INFORMANT <b>J.W. Wilbur F. Miller, 104 N. Bentz St. Frederick,</b>		Address <b>Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1519</u> <u>Asbestosis</u> <u>Stomach</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-7</u> , 19 <u>65</u> , to <u>3-22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Thomas E. Stone</i>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>March 24, 1969</b>				
22d. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M.D.</b>		22e. ADDRESS <b>4 W. Third Street, Frederick, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 24, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>Frederick</b>		(County) <b>Frederick</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <i>Donald M. Etchison</i>		ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Md.</b>	25a. REC'D BY REGISTRAR <b>MAR 26 1969</b>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03885

03892

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED NAME (Type or print)		First <b>Lillie</b>	Middle <b>Elizabeth</b>	Lost	2a. DATE OF DEATH Month <b>March</b>	2b. HOUR Day <b>10</b> Year <b>1969</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>	S. DATE OF BIRTH <b>August 20, 1885</b>	6. AGE (In years last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN. <b>pm</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>920 N. Market Street</b>	
14. FATHER'S NAME First <b>John</b>		Middle <b>Matthew</b>	Lost <b>Spaulding</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b>Becraft</b>	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. - (If yes give war or dates of service) <b>220 44 8258</b>		17. INFORMANT <b>Mrs. Richard F. Kline, Frederick, Maryland</b>	Address	
IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4360</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <b>Recent coronary.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>69</b> , to <b>March</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 10</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>A. Austin Pearre</b>		DEGREE <b>MD.</b>	ATTENDING PHYS. <b>MD.</b>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>March 11, 1969</b>
22d. PHYSICIAN'S NAME (Type) <b>A. Austin Pearre, Jr.</b>		22e. ADDRESS <b>Toll House Ave, Frederick, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 12, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Damascus Meth. Cemetery</b>	23d. LOCATION (City or Town) <b>Damascus</b>	(County) <b>Montgomery</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		ADDRESS <b>Federal</b>	25a. REC'D BY REGISTRAR <b>MAR 12 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Minerva W. Etchison</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03893  
Item6 FilmG410 3/20/69 kk

## CERTIFICATE OF DEATH

03886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <b>David</b>	Middle <b>Emory</b>	Last <b>Nelson</b>	2o. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>69</b> 2b. HOUR <b>6:35P.M.</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	S. DATE OF BIRTH <b>7/8/1890</b>	6. AGE (In years at birthday) <b>79</b> 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>	
10. CITY OR TOWN OF DEATH <b>Knoxville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Residence</b>	12a. USUAL OCCUPATION (Kind of work done during working hours) <b>Retired Trainman E&amp;N R.R.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Freight</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Knoxville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First <b>James</b>	Middle <b>Emory</b>	Last <b>Nelson</b>	15. MOTHER'S MAIDEN NAME First <b>Hannah</b>	Middle <b>Holmes</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>705-05-7942</b>	17. INFORMANT <b>Mrs. Martha E. Nelson, Knoxville, Md.</b>	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>2509</b> <b>Diabetes Mellitus</b>			DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month Day Year <b>Mar. 14 1969</b>		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) <input type="checkbox"/> (We) <input checked="" type="checkbox"/> attended the deceased from <b>Oct. 5, 1962</b> , to <b>Mar. 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>Mar. 14, 1969</b> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE 	DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b>	22e. ADDRESS <b>Gum Spring Hollow Brunswick, Maryland</b>			
23a. BURIAL CREMATION, REMAINS (specify) <b>BURIAL</b>	23b. DATE <b>3/18/69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Petersville Fred. Md.</b>	
24. FUNERAL DIRECTOR <b>Feeete Funeral Home-</b>	ADDRESS <b>Brunswick, Md.</b>	25a. REC'D BY REGISTRAR <b>MAR 18 1969</b>	25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03894

03887

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>EARL</b>	Middle <b>CHARLES</b>	Last <b>NUSE</b>	2a. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>69</b>	2b. HOUR M		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>1/II/02</b>			6. AGE (In years at birthday) <b>67</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. COUNTY OF DEATH <b>Frederick</b>					
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or nursing home)	12a. USUAL OCCUPATION (Kind of work done or being worked when deceased)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Knoxville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>R.R.1</b>				
14. FATHER'S NAME First <b>Jacob</b>	Middle <b>L.</b>	Last <b>Nuse</b>	15. MOTHER'S MAIDEN NAME First <b>Ada</b>	Middle <b>V.</b>	Last <b>Ayers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	16c. INFORMANT <b>705-I0-2739</b>	17. ADDRESS <b>Bettie J. Midgett-Knoxville, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 day</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <b>Chronic nephritis</b> DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause last. (c) <b>multiple myeloma</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <b>1</b>	City or Town <b>Frederick</b>	County <b>Md.</b>	State		
22o. I certify that (I) (this hospital) attended the deceased from <b>2/20/68</b> , to <b>5 March 1969</b> , that (I) (we) last saw the deceased alive on <b>4 March 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Charles H. Conley Jr. M.D.</b>		DEGREE <b>MD.</b>	ATTENDING PHYS. <b>A</b>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>5 March 1969</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>FREDERICK, Md.</b>						
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <b>3/8/69</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Park Heights Cemetery</b>			23d. LOCATION (City or Town) <b>Brunswick</b>	(County) <b>Fred.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Feeete Funeral Home</b>		ADDRESS <b>Brunswick, Md.</b>	25a. RECEIVED BY REGISTRAR DATE <b>MAR 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Alvester Judge</b>		

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FOR STATE  
HEALTH DEPT.

**ROBERT DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03895

03888

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Doy	Year	2b. HOUR	
George			Wilbur	Osmun		3	19	1969	4:30 P.M.		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD				2d. HOUR	
Male	White	Oct. 29-1876	92	MONTHS	DAYS	HOURS	MIN.	Month	Doy	Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
New Jersey		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			1301 Motter Ave.			Retired Minister					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Frederick			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1301 Motter Ave.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John			W.	Osmun		Emma					Cook
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			212-38-8622			Mrs. Sarah E. White Osmun- Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Arteriosclerotic Cardiovascular Disease</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Robert J. Thomas</u> EXAMINER'S NAME (Type) Robert J. Thomas, M.D.											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)		
Burial			Mar. 22-1969			Mt. Olivet Cemetery			Frederick- Frederick- Md.		
24. FUNERAL DIRECTOR <u>Elwood T.</u> M.R. Etchison & Son			ADDRESS <u>Whitmore</u> <u>Frederick, Md. 21701</u>			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						DAT MAR 24 1969			<u>Charles S. S.</u>		

**ROBERT DEPUTY**  
812 TOLL RD  
**FREDERICK, MARYLAND**  
VR A15ME (5)  
10M REV. 1/68

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03896

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03889

1. DECEASED NAME (Type or Print)		First <b>Roger</b>	Middle <b>L.</b>	Last <b>Roles</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month <b>3</b>	Day <b>29</b>	Year <b>1969</b>	2b. HOUR <b>2:35 P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3/14/1948</b>	6. AGE (In years last birthday) <b>21</b>	IF UNDER 1 YEAR  MONTHS <b>0</b>	IF UNDER 24 HRS.  DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>3</b>	Day <b>29</b>	Year <b>1969</b>	2d. HOUR <b>2:15 A.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>								
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>2005 Stanley Avenue</b>								
14. FATHER'S NAME First <b>John</b>	Middle <b>Earl</b>	Last <b>Roles</b>	15. MOTHER'S MAIDEN NAME First <b>Ruby</b>	Middle <b></b>	Last <b>Parker</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>Viet Nam 51-663-428</b>	17. INFORMANT <b>John E. Roles</b>	ADDRESS <b>Same as item #13e.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LACERATED BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>CRUSHED SKULL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>819.9</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?						
19c. MEDICAL CERTIFICATION					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>	21f. LOCATION Street or R.F.D. No. <b>MT Airy</b>	City or Town <b>Carroll</b>	County <b>Md.</b>	State <b></b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22b. DATE SIGNED <b>3-29-69</b>					
ACTUAL SIGNATURE <b>Robert J. Thomas</b>		CHIEF MEDICAL EXAMINER <b>Robert J. Thomas</b>			ASSISTANT MEDICAL EXAMINER <b></b>						
EXAMINER'S NAME (Type) <b>Robert J. Thomas</b>		DEPUTY MEDICAL EXAMINER <b></b>			ADDRESS (Street, city, town, or county) <b></b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/2/69</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	23d. LOCATION (City or Town) <b>Baltimore, Maryland</b>	(County) <b></b>	(State) <b></b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rockville Pike Rockville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>APR 7 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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SHREVEPORT, LA - 2000 - 012

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. In case of delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												MEDICAL EXAMINER'S CERTIFICATE OF DEATH												03890	
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR							
			Arie			Rebecca			Routzahn			<input checked="" type="checkbox"/>			3	13	1969	10:00 AM							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR						
Female		White		Jan. 29-1892			77 YRS.		MONTHS		DAYS		HOURS		<input checked="" type="checkbox"/>			3	13	1969	11:00 M				
7b. CITIZEN OF WHAT COUNTRY?			U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Frederick							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)								12b. KIND OF BUSINESS OR INDUSTRY					
Frederick				DOA-Fred'k. Mem. Hospital								Housekeeper								Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER													
Md.				Frederick				Frederick				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Route 10									
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last									
Charles			Henry		Routzahn				Phebe							Cramer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT								ADDRESS									
No				220-44-1053				Harry C. Routzahn-Route 10-Frederick-Md. 21701																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a)												Acute Gastroenteric Heart Failure													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF  (b) Arteriosclerotic Cardiovascular Disease													
(c)																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?													
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County		State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																									
ACTUAL SIGNATURE		R. J. Thomas, M. D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-13-69							
EXAMINER'S NAME (Type)																									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL								23d. LOCATION (City or Town)		(County)		(State)									
Burial		Mar. 15-1969		Mt. Olivet Cemetery								Frederick		Frederick		Md. 21701									
24. FUNERAL DIRECTOR		Elwood T.		ADDRESS Whitmore								25a. REC'D BY REGISTRAR		25b. REC'D BY REGISTRAR'S SIGNATURE											
		M.R. Etchison & Son		Frederick, Md. 21701								MAR 17 1969													



**FOR STATE  
HEALTH DEPT.**

**ROBERT H. TOLL**, M.D., F.A.C.P.  
812 TOLL ST., FREDERICK, MD. 21701  
TELEPHONE: 301-652-1111  
**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four ~~PAGE 5~~ <sup>1</sup> ~~PAGE 3~~ <sup>2</sup> ~~PAGE 4~~ <sup>3</sup> ~~PAGE 5~~ <sup>4</sup> ~~PAGE 6~~ <sup>5</sup> ~~PAGE 7~~ <sup>6</sup> ~~PAGE 8~~ <sup>7</sup> ~~PAGE 9~~ <sup>8</sup> ~~PAGE 10~~ <sup>9</sup> ~~PAGE 11~~ <sup>10</sup> ~~PAGE 12~~ <sup>11</sup> ~~PAGE 13~~ <sup>12</sup> ~~PAGE 14~~ <sup>13</sup> ~~PAGE 15~~ <sup>14</sup> ~~PAGE 16~~ <sup>15</sup> ~~PAGE 17~~ <sup>16</sup> ~~PAGE 18~~ <sup>17</sup> ~~PAGE 19~~ <sup>18</sup> ~~PAGE 20~~ <sup>19</sup> ~~PAGE 21~~ <sup>20</sup> ~~PAGE 22~~ <sup>21</sup> ~~PAGE 23~~ <sup>22</sup> ~~PAGE 24~~ <sup>23</sup> ~~PAGE 25~~ <sup>24</sup> ~~PAGE 26~~ <sup>25</sup> ~~PAGE 27~~ <sup>26</sup> ~~PAGE 28~~ <sup>27</sup> ~~PAGE 29~~ <sup>28</sup> ~~PAGE 30~~ <sup>29</sup> ~~PAGE 31~~ <sup>30</sup> ~~PAGE 32~~ <sup>31</sup> ~~PAGE 33~~ <sup>32</sup> ~~PAGE 34~~ <sup>33</sup> ~~PAGE 35~~ <sup>34</sup> ~~PAGE 36~~ <sup>35</sup> ~~PAGE 37~~ <sup>36</sup> 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Item6 FilmG411 MARYLAND STATE DEPARTMENT OF HEALTH  
4/2/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
02800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03891

1. DECEASED-NAME (Type or Print)		First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		Month Day Year	2b. HOUR			
Clarence Preston Sampsell					<input checked="" type="checkbox"/> 3 24 1969		1 PM	M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years (as of birthday) YRS.)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2d. HOUR			
Male	White	Sept. 15, 1921	74	MONTHS	DAYS	HOURS	MIN.	1 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Bunker Hill, W. Va.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick		Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick			Grederick Memorial Hospital			Warehouse Man.			Bldg. Supplies		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Route # 8 Box 122				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
John			Albert	Sampsell	Lottie Mae				Bowers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			217-12-2724			Mrs. C.P. Sampsell R #8 Box 122			Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteria Sclerotic Cardiovascular Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Nebulizer</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
M.D. ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Robert J. Thomas, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-24-69			
EXAMINER'S NAME (Type)		Robert J. Thomas, M.D.		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		Robert J. Thomas, M.D.		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATIION, REMOVAL (Specify) Burial										ADDRESS	ADDRESS (Street, city, town, or county)
23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)			(County)	(State)	
3/27/69			Rest Haven Cemetery			Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. A. Host		Rest Haven Funeral Chapel		Hagerstown, Md.		Charles Jones					
DATE MAR 28 1969											

39200

40000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

03899

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03892

1. DECEASED-NAME (Type or print)	First Carmen	Middle Margaret	Last Simpson	20. DATE OF DEATH Month March	Day 3	Year 69	2b. HOUR 11:30 AM
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 9-1898</b>			6. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Frederick</b>				
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY _____
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>244 W. 5th. St.</b>			
14. FATHER'S NAME First Not available	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last Klipp				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>219-54-1046</b>	17. INFORMANT <b>Frederick Chas. W. Simpson-Jr.-202 Rockwell Terrace-</b>	Address <b>Md. 21701</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>RECENT POST. MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1968</b> , to <b>3 MAR 1969</b> , that (I) (we) last saw the deceased alive on <b>3 MAR 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George I. Smith</b>	R.D. DEGREE <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>3 MAR 69</b>					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <b>George I. Smith, Jr.</b>			22f. ADDRESS <b>804 Toll House Ave.-Frederick, Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 6-1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick Frederick- Md.</b>				
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>	ADDRESS <b>Whitmore Frederick, Md. 21701</b>	25a. RECD BY REGISTRAR DATE <b>MAR 10 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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RECEIVED INFORMATION FROM STATION

NOVEMBER 1967

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03900

03893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 8:55 AM	
		<b>Blanche</b>	<b>S.</b>	<b>Summers</b>	<b>March 26 1969</b>		
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday) 52 yrs.		
<b>female</b>		<b>Caucasian</b>		<b>9/15/1917</b>	<b>9/16/1968</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Rural Middletown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route # 1</b>		
14. FATHER'S NAME First <b>Ethan</b>		Middle <b>Alan</b>	Last <b>Angle</b>	15. MOTHER'S MAIDEN NAME First <b>Pearl</b> Middle <b>Householder</b> Last <b>Angle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO. - - -		17. INFORMANT <b>Vernon A. Summers, Rt. 1 Middletown, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b>		C. <b>Carcinoma of breast</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Adenocarcinoma left breast 2 yrs</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma left breast 2 yrs</b>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION <b>7/28/67</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Breast ex</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/28/67</b> to <b>3/26/69</b> , that (I) (we) last saw the deceased alive on <b>3/25/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Frank J. Damato</b>		DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED <b>3/26/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>FRANK J. DAMATO</b>		22e. ADDRESS <b>700 Middletown Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 29, 1969</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion U. Meth.</b>	23d. LOCATION (City or Town) <b>Myersville, Md.</b>	(County) <b>Fred. Co. Md.</b>	(State)	
24. FUNERAL DIRECTOR <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b>	25a. RECEIVED BY REGISTRAR DATE <b>APR 1 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3  
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03901

CERTIFICATE OF DEATH

3  
03894

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print) <b>Leona</b>				First <b>P.</b>	Middle <b>Tressler</b>	Lost	2a. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>69</b>	2b. HOUR <b>1:15 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 13-1899</b>		6. AGE (In years lost birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			
10. CITY OR TOWN OF DEATH <b>Braddock Heights</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Vindobona Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Jefferson</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>Luther</b>		Middle <b>Mann</b>	Lost	15. MOTHER'S MAIDEN NAME First <b>Nora</b>		Middle	Lost	<b>Trittapee</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>218-40-3676A</b>		17. INFORMANT <b>Harold S. Virtz</b>		Address <b>53 Winchester St.-Frederick-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Myocardial Infarction</b> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF noy your									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour -									
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) <b>Hypothyroidism, Anemia, Emphysema</b>									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (1) (this hospital) attended the deceased from Jan. 1966, to March 1969, that (1) we lost saw the deceased alive on March 1 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>W.J. Riddick</b>		DEGREE <b>ATTENDING PHYS.</b>	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <b>Mar. 6-1969</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. J.R. Poirier or W.J. Riddick</b>		22e. ADDRESS <b>Fred'k. Medical Center-Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 8-1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>		23d. LOCATION (City or Town) <b>Lovettsville-Virginia</b> (County) (State)			
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>		25a. ADDRESS <b>Whitmore Frederick, Md. 21701</b> REC'D BY REGISTRAR <b>MAR 10 1969</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

8000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03895

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1		03902												3		19		69		9 45 PM	
I. DECEASED-NAME (Type or print)		First Gertrude		Middle Anna		Last Troxell		2a. DATE OF DEATH Month 3		Day 19		Year 69		2b. HOUR 9 45 PM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 16, 1875		6. AGE (In years last birthday) 93 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Frederick		10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired). Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. # 3													
14. FATHER'S NAME First John		Middle Moser		15. MOTHER'S MAIDEN NAME First Elizabeth		Middle Barton		Last													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-20-9291-F2		17. INFORMANT Harry Troxell, Thurmont, Maryland		Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4124 Cardiac arrest		DUE TO, OR AS A CONSEQUENCE OF (b) Adams - Stokes syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) Artherosclerotic cardiovascular disease		4 weeks 3 years,															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1965</u> , to <u>March 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1969</u> , and (I) (we) (did) (did not) in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Le Roy T. Davis		22c. DATE SIGNED 3/19/69		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.															
22d. PHYSICIAN'S NAME (Type) Le Roy T. Davis		22e. ADDRESS Frederick, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 23, 1969		23c. NAME OF CEMETERY OR CREMATORIUM Elias Lutheran Cemetery		23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md.		(County)		(State)											
24. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg, Md.		25a. REGD. BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE James Judge															
Clarence E. Wilson																					

DEPARTMENT OF THE ARMY - U.S. GOVERNMENT

ARMY AIR FORCE

SP-20

ARMED FORCES INFORMATION CENTER

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

03903

## **CERTIFICATE OF DEATH**

03896

1. DECEASED-NAME (Type or print)			First Joseph	Middle T.	Last Tucker	2a. DATE OF DEATH Month March	2b. HOUR Year 23 1969				
3. SEX <input checked="" type="checkbox"/> Male		4. RACE <input checked="" type="checkbox"/> White		5. DATE OF BIRTH August 11, 1884		6. AGE (In years at birthday) 84		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <input checked="" type="checkbox"/> Maryland		7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Frederick					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Md.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> STATE Maryland		13c. CITY OR TOWN Urbana		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER Route 2					
14. FATHER'S NAME Edward		First F.	Middle Tuckern	Last Sr.	15. MOTHER'S MAIDEN NAME Sallie		Last Mull				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Miss Margaret Tucker, Route 2, Frederick, Md.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  4123		DUE TO, OR AS A CONSEQUENCE OF  (b) Bronchopneumonia				5 days					
		DUE TO, OR AS A CONSEQUENCE OF  (c) Arteriosclerotic heart Disease				20 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from NOV. 16, 1966, to MAR. 23, 1969, that (I) (we) last saw the deceased alive on MAR 23 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ralph L. Michels, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Mar 24,				
22d. PHYSICIAN'S NAME (Type)		Ralph L. Michels, M.D.		22e. ADDRESS Frederick Medical Center, Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 25, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City or Town) Frederick		(County) Frederick	(State) Md.		
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.		ADDRESS Frederick		25a. RECD BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Juspe					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

COEGG

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03904

03897

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Walter</b>	Middle <b>J</b>	Last <b>VAN WESTENBERG</b>	20. DATE OF DEATH Month <b>3</b>	Day <b>31</b>	Year <b>69</b>	2b. HOUR <b>4:10 AM</b>			
3. SEX <b>M</b>		4. RACE <b>White</b>		S. DATE OF BIRTH <b>AUG. 19<sup>th</sup>, 1901</b>	6. AGE (In years lost birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	
7b. BIRTHPLACE (State or foreign country) <b>Colorado</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Frederick</b>						
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>self-emp.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Middletown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Reno Monument Rd. R.D2</b>					
14. FATHER'S NAME First <b>Herbert</b>		Middle <b></b>	Last <b>VanWestenberg</b>	15. MOTHER'S MAIDEN NAME First <b>Cora</b>	Middle <b></b>	Lost <b>Unkn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>523-74-0488</b>		17. INFORMANT <b>Vera Van Westenberg</b>	Address <b>R.F.D.2 Middletown, Md.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART I. DEATH WAS CAUSED BY:  <b>IMMEDIATE CAUSE (a) Cardiac Arrest</b>  <b>4122</b>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b) Hypertensive + Arterio Sclerotic Cardiovascular Disease</b>          DUE TO, OR AS A CONSEQUENCE OF  <b>(c)</b>          DUE TO, OR AS A CONSEQUENCE OF  <b>—</b></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) ( <b>Ralph L. Michels, M.D.</b> ) attended the deceased from <b>MAY 5, 1965</b> , to <b>MAR. 31, 1969</b> , that (I) ( <b>✓</b> ) last saw the deceased alive on <b>MAR. 30, 1969</b> , and that in (my) ( <b>✓</b> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <b>✓</b> ) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ralph L. Michels, M.D.</b>		DEGREE <b>MD.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>APR. 1<sup>st</sup>, 69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Ralph L. Michels, M.D.</b>		22e. ADDRESS <b>Medical Center, Frederick, Md. 21701</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 2, 1969</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lutheran Cemetery</b>		23d. LOCATION (City or Town) <b>Middletown Fred. Md.</b>		(County) <b></b>		(State) <b></b>	
24. FUNERAL DIRECTOR <b>Gladhill Co.</b>		ADDRESS <b>Middletown, Md. 21769</b>		25a. REC'D BY REGISTRAR <b>APR 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Gloria J. Judge</b>					

30820

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03905

03898

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 8:40 P.M.	
		Charles	Nicholas	Washington	March	23	1969		
3. SEX		4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 79 YRS.					
Male		Negro	2-16-1890	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick			
Maryland		U.S.A.							
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Water Dept.		12b. KIND OF BUSINESS OR INDUSTRY 42 Carver Apt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 42 Carver Apt., Fred. Md.			
14. FATHER'S NAME First John Middle NMN Lost Washington		15. MOTHER'S MAIDEN NAME First Mallissa Middle NMN Lost Pratter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO. *****		17. INFORMANT William E. Blackston		Address			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Cerebral vascular accident		APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bronchopneumonia; generalized arteriosclerosis & chronic congestive heart failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 17 MAR, 1969, to 23 MAR, 1969, that (I) (we) last saw the deceased alive on 23 MAR 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22b. SIGNATURE George I. Smith Jr.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 804 Toll House Ave, Fred. Md		22c. DATE SIGNED 23 MAR 69.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-1969		23c. NAME OF CEMETERY OR CREMATORIUM Fairview		23d. LOCATION (City or Town) Frederick		(County) Fred.	(State) Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 263 W. Patrick St, Fred. Md		ADDRESS		25a. RECD BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE George J. Hicks			

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FOR STATE  
HEALTH DEPT.

ROBERT J. THOMAS, M.D.  
812 TOLL HOUSE ROAD, FREDERICK, MARYLAND 21701  
TOLL FREE 1-800-432-1234  
FAX 301-662-1234  
E-MAIL: ROBERTJTHOMAS@AOL.COM  
URL: <http://www.robertjthomas.com>

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03899

Any delay is  
harmful to the deceased. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Doy	Year	2b. HOUR		
		Harry	Charles	Wolfe, Sr.	<input checked="" type="checkbox"/> 13	8	1969	8 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS    DAYS	IF UNDER 24 HRS. HOURS    MIN.	2c. DATE PRONOUNCED DEAD Month    Day    Year			2d. HOUR		
Male	Negro	12-26-1880	88 YRS.			3	8	1969	10 A.M.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Pa.	U.S.A.				Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Adamstown		Park Mills Rd Rt 1			Bldg Contractor			*****			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Md	Frederick	Adamstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Park Mills Rd Rt 1							
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost			
		Calvin	NMN	Wolfe	Ruth	NMN	Ricketts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		215-20-9857		Martha Wood		154-46th St N.E. Washington D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular Heart Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cerebrovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Robert J. Thomas, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3-10-69			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City or Town)		(County)	(State)
Burial		3-11-1969		Fairview				Frederick		Fred.	Md.
24. FUNERAL DIRECTOR		ADDRESS		25a. REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C.E. Hicks, 111 Frederick, Md				MAR 12 1969		Charles J. Hicks					
DATE											

